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Medicaid Coverage and Spending in Health Reform:
National and State-by-State Results for Adults at or Below 133% FPL

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

Executive Summary

The Patient Protection and Affordable Care Act (PPACA) expands Medicaid to nearly all individuals under age 65 with incomes up to 133 percent of the federal poverty line (FPL) which will extend coverage to large numbers of the nation's uninsured population, especially adults. However, the ultimate reach of the program will depend heavily on both federal and state actions to implement the new law. The Congressional Budget Office (CBO) has provided national estimates of the impacts of health reform, but does not provide state-by-state estimates. We know that the impact of health reform will vary across states based on coverage levels in states today. This analysis provides national and state-by-state estimates of the increases in coverage and the associated costs compared to a baseline scenario without the Medicaid expansions in health reform. Nationally and across states, this analysis shows that:

- ***Medicaid expansions will significantly increase coverage and reduce the number of uninsured***
- ***The federal government will pay a very high share of new Medicaid costs in all states***
- ***Increases in state spending are small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted***

Today there is a great deal of variation across states in terms of Medicaid coverage, the uninsured, state fiscal capacity, leadership and priorities. These variations make it impossible to know how each state individually will respond to the new health reform law. There are a range of implementation scenarios that will impact the number of people who participate or sign up for coverage and these participation rates are directly related to the estimates of coverage and cost for health reform. Since it is impossible to predict the behavior of each state, this analysis examines two participation rate scenarios that are applied uniformly across states; however, we recognize that some states may implement reform to achieve coverage levels above expectations and others may be slower to implement reform or face implementation barriers that result in lower coverage levels. The two modeled scenarios are:

1. ***Standard Participation Scenario.*** This scenario attempts to approximate participation rates used by the CBO to estimate the national impact of the Medicaid expansion and then examines the results by state. These results assume moderate levels of participation similar to current experience among those made newly eligible for coverage and little additional participation among those currently eligible. This scenario assumes 57 percent participation among the newly eligible uninsured and lower participation across other coverage groups.

2. ***Enhanced Outreach Scenario.*** This scenario examines the impact and reach of Medicaid assuming a more aggressive outreach and enrollment campaign by federal and state governments as well as key stakeholders including community based organizations and providers that would promote more robust participation among those newly eligible (75 percent participation among the newly eligible that are currently uninsured and lower participation across other coverage groups) and higher participation among those currently eligible for coverage than in the standard scenario.

Even in a scenario with higher participation, we did not assume that there will be full or 100 percent participation. We did not model a participation rate lower than the standard, but this scenario might result in coverage levels that are not a substantial improvement over what would have occurred in the absence of reform (or baseline levels).

This analysis estimates the impact of the coverage provisions for adults in health reform between 2014 and 2019 but does not account for other Medicaid changes in the law. For a more detailed description of the methods used in the analysis for this brief and a description of how the changes in the Medicaid match rates are applied to different populations, see the full text of the report and boxes 1 and 2 at the end of the executive summary.

Standard Participation Scenario

This scenario assumes that states will implement health reform and achieve levels of participation similar to current enrollment in Medicaid among those made newly eligible for coverage; however, this scenario assumes little additional participation among those currently eligible. These results attempt to approximate participation rates used by the CBO.

National Results

Medicaid expansions will significantly increase coverage and reduce the number of uninsured. Medicaid enrollment is projected to increase by 15.9 million by 2019. This new coverage would result in a reduction of uninsured adults under 133 percent of poverty of 11.2 million, a 45 percent reduction in 2019 (Figure 1). States with more limited coverage and higher uninsured rates pre-reform (like Texas) will see larger decreases in the uninsured compared to states with broader coverage and fewer uninsured pre-reform (like Massachusetts).

The federal government will pay a very high share of new Medicaid costs in all states. In this scenario, federal spending would increase by $443.5 billion and state spending would increase by $21.1 billion between 2014-2019 (Figure 2). Thus about 95 percent of all new spending would be by the federal government. Spending in 2014 is expected to be relatively small, particularly for states because enrollment is being phased-in and the federal matching rate for new eligibles is 100 percent. Overall and state spending increases by 2019 as coverage is phased in to full implementation levels and federal matching rates for new eligibles fall to 93 percent from 100 percent.

Figure 1

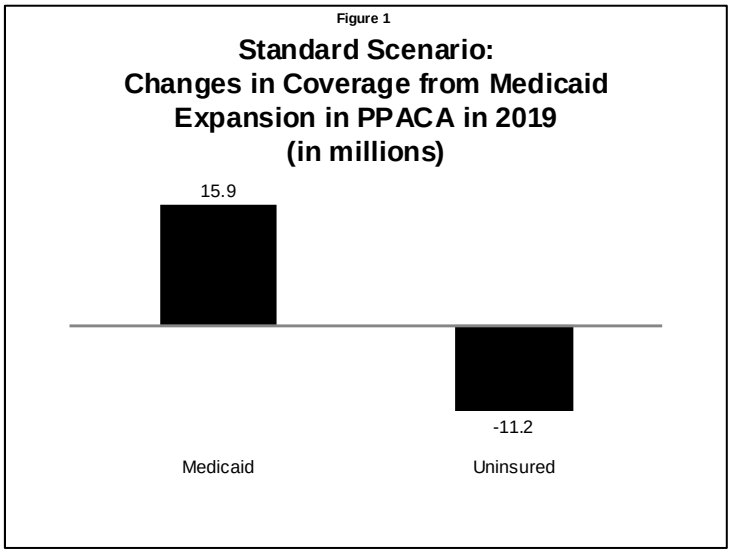
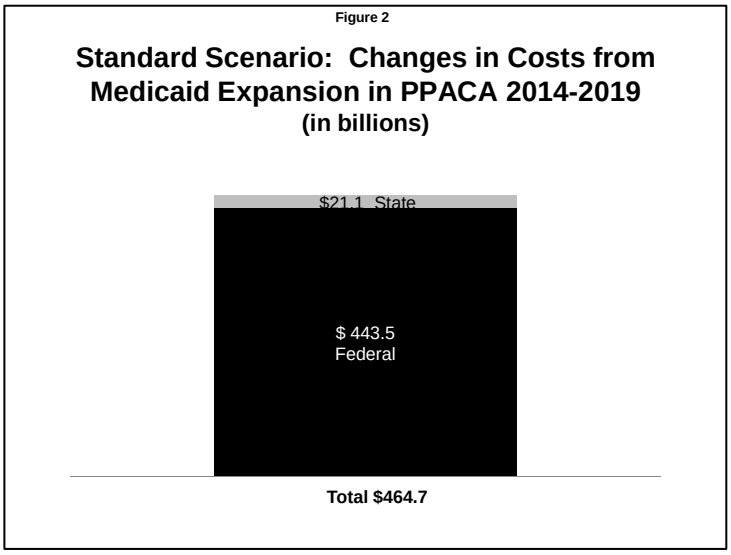


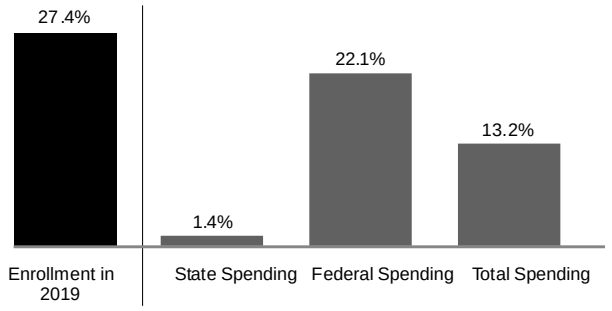
Figure 2



Increases in state spending are small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted (baseline). Nationally, enrollment is expected to increase by 27.4 percent compared to baseline. This increase in enrollment far exceeds increases in state spending relative to baseline of 1.4 percent. Due to the large increase in federal matching rates, the federal increases in Medicaid spending compared to baseline are expected to be 22.1 percent with overall spending increases of 13.2 percent. (Figure 3) The federal matching rates pre-reform and pre-ARRA average 57.1 percent. The federal matching rate after reform is the combination of current matching rates on current eligibles, expansion state match rate for certain childless adults, and the higher federal matching rates on new eligibles. The aggregate match rates for Medicaid or the share of total Medicaid spending financed by the federal government is expected to increase from 57.1 percent (under current law) to 61.6 percent; however, states that have had large increases in the number of new eligibles will see the greatest increases in matching rates.

Figure 3

Standard Scenario: Enrollment and Spending Increases Over Baseline 2014-2019



State-by-State Results

The impact of the Medicaid expansions under health reform will vary across states based on current levels of coverage and current match rates for states. The next section reviews the variation in the impact of costs and coverage across states. For state-by-state results of the standard scenario see Table 1. For purposes of this discussion we group the results into the experience in three types of states. For each group we will use the results from two states as illustrative of the experience for other states in that group:

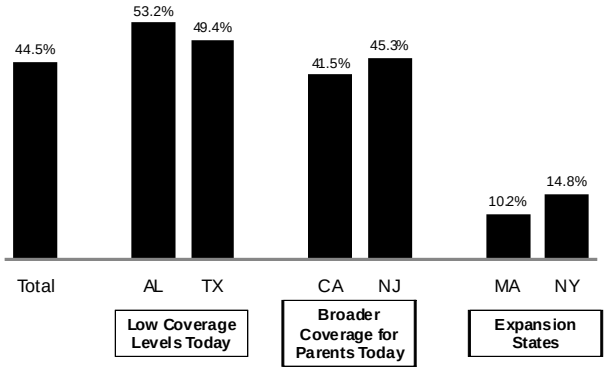
- States with low Medicaid eligibility for adults today (Alabama and Texas)
- States that have broader coverage today for parents but have no Medicaid coverage for childless adults (California and New Jersey), and
- Expansion states that cover both parents and childless adults in Medicaid today (Massachusetts and New York). [1]

[1] For this analysis we assume that there are seven "expansion states" which include: Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont.

The Medicaid expansion will result in large reductions in the uninsured across states, but especially in states that have higher levels of uninsured today. Overall, the Medicaid expansion is expected to result in a decrease in the number of uninsured of 11.2 million people, or 45 percent of the uninsured adults below 133 percent of poverty. States with low coverage levels and higher uninsured rates today will see larger reductions (Alabama 53.2 percent and Texas 49.4). States with broader coverage levels for parents today, no coverage for childless adults and high uninsured rates will also see large reductions in the uninsured (California 41.5 percent and New Jersey 45.3 percent). States with lower uninsured rates today will see smaller reductions (Massachusetts 10.2 percent reduction and New York 14.8 percent). (Figure 4) Overall, Texas and California could each see a reduction in the uninsured of about 1.4 million compared to baseline in 2019.

Figure 4

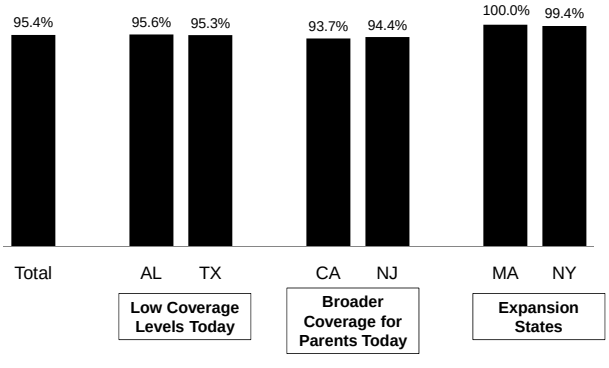
Standard Scenario: Percent Reduction in Uninsured Adults < 133% FPL Due to Medicaid Expansion in 2019



The actual federal share of the costs of the Medicaid expansion varies based on state coverage levels today, but it is always very high. States with low coverage levels today will see the vast majority of the costs of new enrollment financed by the federal government over the 2014 to 2019 period because most of their increased enrollment is from individuals made eligible by health reform who qualify for the high newly eligible match rate (for Alabama, 96 percent and Texas, 95 percent). States with broader coverage of parents today have the majority of costs financed by the federal government, but at slightly lower levels because they experience a higher participation of those currently eligible whose coverage is reimbursed at the states' regular match rates (California, 94 percent and New Jersey 94 percent). For expansion states, the level of federal financing varies with the proportion of current eligibles to newly eligible or those eligible for the expansion match rate. Massachusetts, a state with no new eligibles, will actually achieve some savings because the benefit of the expansion match rate for current and new coverage of childless adults outweighs any new state costs related to increases in participation for parents at the regular Medicaid match rate. States with state funded coverage programs for adults benefit because these adults will be considered newly eligible for Medicaid and qualify for the newly eligible match rate. Generally, states will benefit from a large influx of federal dollars and new coverage is likely to reduce the need for state payments for uncompensated care. (Figure 5)

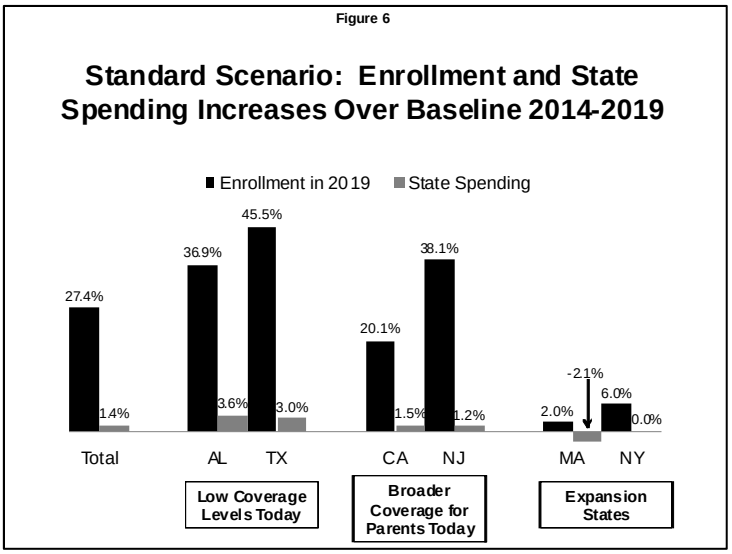
Figure 5

Standard Scenario: Federal Share of Costs of the Medicaid Expansion 2014-2019



Compared to projected enrollment without health reform, increases in new enrollment and coverage will far exceed new state costs, but these increases vary based on current levels of coverage across states. States with more modest coverage today are expected to see large increases in enrollment compared to projections without health reform. Increases in enrollment will be lower in states that have already covered a large share of these populations. Increases in enrollment far exceed increases in state spending relative to baseline estimates and this differential is biggest in states with low coverage today. For example, Texas could see an increase in enrollment of 46 percent but an increase in state spending of about 3 percent. Federal spending in Texas is expected to increase by 39 percent compared to baseline. States with low coverage today are expected to see large increases in federal spending relative to baseline both because of the very favorable matching rate on new eligibles and because these states also have a high regular Medicaid match rate for current eligibles. Increases in coverage and spending will be lower in states that have already covered a large share of these populations. (Figure 6)

Figure 6

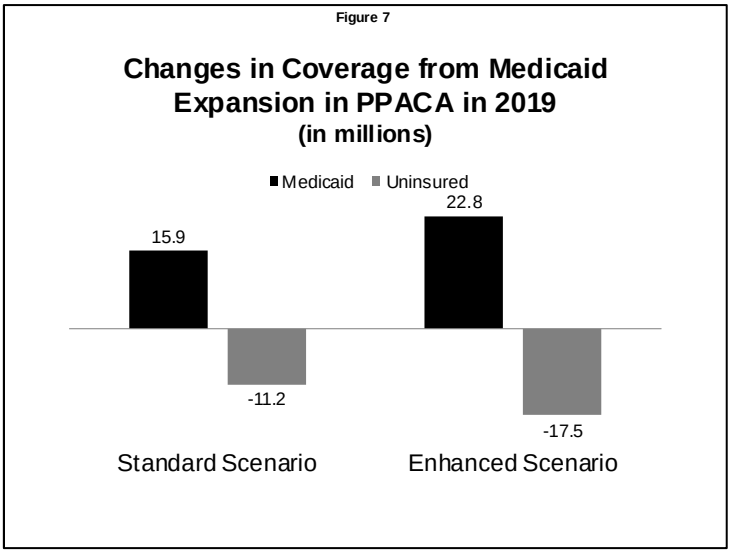


Enhanced Outreach Scenario

This scenario examines the impact on Medicaid and the uninsured assuming a more aggressive outreach and enrollment campaign at both the federal and state levels that would promote more robust participation in Medicaid and further reduce the number of uninsured in this low-income population compared to the standard scenario. The enhanced scenario also assumes that individuals respond favorably to the new mandate for coverage. Even though the large majority of those eligible for Medicaid will be exempt from the penalties for failure to comply with the mandate, a new culture of coverage along with outreach efforts are likely to yield more participation. These factors would increase participation of both those made newly eligible for coverage under health reform and eligible for coverage prior to changes in reform.

Under the enhanced outreach scenario applied uniformly across states, Medicaid enrollment could increase by 22.8 million by 2019 resulting in a 17.5 million reduction in uninsured adults under 133 percent of poverty (a 70 percent reduction). (Figure 7)

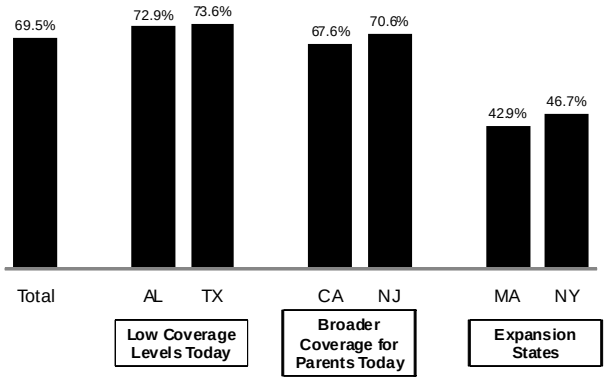
Figure 7



Compared to the standard scenario, states will see larger reductions in the uninsured. Similar to the standard scenario, states with low coverage levels today will see larger reductions (Alabama 73 percent and Texas 74 percent). States with broader coverage levels for parents but no coverage for childless adults and high uninsured rates will also see large reductions in the uninsured (California 68 percent and New Jersey 71 percent). States with lower uninsured rates today will see smaller reductions (Massachusetts 43 percent reduction and New York 47 percent). (Figure 8) In this scenario, California could see a reduction in the uninsured of 2.3 million and Texas could see a 2.1 million reduction compared to baseline projections in 2019. See Table 2 for the state-by-state results of the enhanced participation scenario.

Figure 8

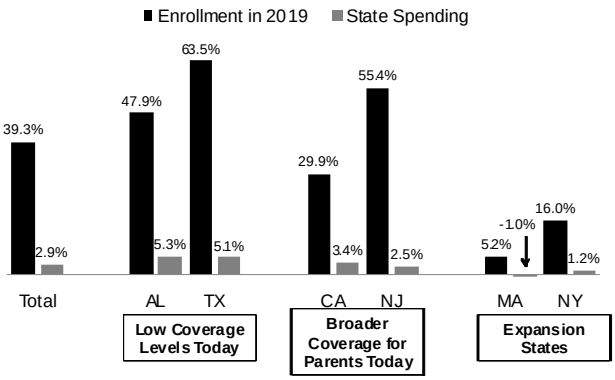
Enhanced Scenario: Percent Reduction in Uninsured Adults < 133% FPL Due to Medicaid Expansion in 2019



Under these higher participation assumptions, new spending for Medicaid would continue to be mostly federal (92.5 percent) over the 2014 to 2019 period. State spending could increase by $43 billion while federal spending could increase by $532 billion. The share of spending borne by the federal government will be somewhat lower under the higher participation assumptions, primarily due to higher take-up among those who are eligible under pre-PPACA rules. Since the states will receive lower federal matching rates for those previously eligible, states will be responsible for a higher share of their costs. Relative to baseline spending, Medicaid enrollment could increase by 39 percent, significantly higher than state spending increases of 2.9 percent. Federal spending nationally in this scenario could be about 27 percent higher than baseline projections. (Figure 9) . In this scenario, the aggregate match rates for Medicaid or the share of total Medicaid spending financed by the federal government is expected to increase from 57.1 percent (under current law) to 62.1 percent; however, states with large increases in the number of new eligibles will see the greatest increases in matching rates.

Figure 9

Enhanced Scenario: Enrollment and State Spending Increases Over Baseline 2014-2019



Limited Outreach Scenario

Right now, states are still in the midst of a major economic downturn facing historic declines in revenues and increased demand for public programs. The impact of the downturn varies across states and the economic recovery will vary across states as well. Heading into health reform, some states will move quickly to promote coverage with efforts that may begin in 2010, while others may move more slowly. Some are challenging and opposing health reform through amendments to their state statutes and constitutions, ballot initiatives and court challenges. Continuing an approach to Medicaid that dates back to its enactment in 1965, health reform revises the standards with which states that choose to participate in the program must comply. Because

Medicaid is voluntary, states may choose to not to participate and thereby forego the federal Medicaid funding to which participating states are entitled. States that elect not to implement these new requirements in effect would be making the choice not to participate.

The outcome of state actions will affect the extent to which implementation of health reform reaches its fullest potential. If states fall short of implementation expectations, fewer individuals will be covered and more individuals will remain uninsured. Under this scenario, states would also forgo large sums of federal funding tied to the coverage of those made newly eligible under reform. Even though states would have higher numbers of uninsured in this scenario, they will also face a reduction in the federal dollars to support uncompensated care since the new law calls for reductions in disproportionate share hospital payments (DSH) of $14 billion over the 2014 to 2019 period.

Conclusion

The changes to the Medicaid program under the Patient Protection and Affordability Care Act (PPACA) significantly expand Medicaid coverage for adults. There will be large increases in coverage and federal funding in exchange for a small increase in state spending. States with low coverage levels and high uninsured rates will see the largest increases in coverage and federal funding. Higher levels of coverage will allow states to reduce payments they make to support uncompensated care costs.

The impact of health reform will vary across states based on coverage levels in states today, state decisions about implementation and ultimately the number of individuals who sign up for coverage. It is impossible to know how individual states will respond, so this analysis looked at a range of participation assumptions that are applied uniformly across states, but in reality this will vary. Some states may not aggressively implement health reform and therefore not see significant reductions in the uninsured while other states will have higher levels of participation because of effective outreach and enrollment strategies and see greater reductions in the number of uninsured.

Box 1: Methods Summary

The Model Database. We use the 2007 and 2008 Current Population Survey (CPS) as our baseline data set (which provides data for 2006 and 2007). It is generally accepted that the CPS has an undercount of the Medicaid population. We adjust for the undercount with a partial adjustment to state administrative data. We then generate a 2009 dataset by growing the population to 2009. We account for the impact of unemployment on coverage which has the effect of reducing employer coverage, increasing Medicaid enrollment, and increasing the number of uninsured. We also benchmark to 2009 CPS total population estimates by state and estimate population growth to 2019 using growth rates based on Census population projections.

Eligibility Simulation. To estimate the impact of health reform on states, we use a model developed at the Urban Institute's Health Policy Center (Health Insurance Policy Simulation Model or HIPSM). The model takes into account state-level eligibility requirements for Medicaid and CHIP eligibility pathways and applies them to person- and family-level data from the Annual Social and Economic Supplement to the CPS to simulate the eligibility determination process. The model identifies eligibility for Section 1115 waiver programs which is critical for determining match rates for coverage in seven states: Arizona, Delaware, Hawaii, Maine, Massachusetts, New York, and Vermont.

Participation Rates. Once we have identified individuals who are newly eligible for Medicaid, we then assess the likelihood that they will participate in Medicaid under reform. The uninsured are likely to participate at relatively higher rates post-reform because they currently lack coverage but not all new participation will come from the ranks of the uninsured. Participation rates are also likely to increase for those who are currently eligible but not participating in Medicaid. Under the standard scenario, we use a set of participation rates that attempt to approximate those used by CBO (57% participation from the uninsured and lower rates for other coverage groups). The actual participation rates assumed in the CBO estimates are not publicly available. We also look at the impact of a scenario with aggressive broader outreach and enrollment efforts and stronger response to the individual mandate (even though the Medicaid population is largely exempt from these requirements). In this scenario we assume 75% participation of the uninsured and lower rates for other coverage groups.

Baseline Coverage	Standard Scenario	Enhanced Scenario
Current Eligibles		
ESI	3%	5%
Non-group	7%	10%
Uninsured	10%	40%
New Eligibles		
ESI	25%	25%
Non-group	54%	60%
Uninsured	57%	75%

Cost per Person. We make estimates on the costs per enrollee using data from HIPSM. These estimates are based on the Medical Expenditure Panel Survey (MEPS) but calibrated to reflect differences in health status of Medicaid eligibles who are currently uninsured, have non-group coverage, or employer-sponsored insurance. Estimates from MEPS are adjusted to be consistent with targets from the Medicaid Statistical Information System (MSIS). Cost per enrollee is then grown to 2019 using growth rates taken from the CBO March 2009 baseline.

The Baseline. We use estimates of state and federal Medicaid spending in the baseline, i.e. what would have happened without reform if current law continued, to assess the impact of reform. Baseline enrollment and national spending totals for the years 2009-2019 were calculated using published CBO estimates from March 2009 to grow data from the 2007 Medicaid Statistical Information Statistics (MSIS) and CMS Form-64 Medicaid Financial Report (CMS-64). Using published Federal Medical Assistance Percentages (FMAP) from the Department of Health and Human Services, we calculated the federal and state share of spending for each state. These 2007 federal spending counts were grown to match 2009 spending from the CBO by enrollment group at the national level. Then these same growth rates were applied to each state. Published 2009 FMAP rates were then used to calculate the state and total spending amounts in 2009. This process was repeated for each year, 2010 through 2019, using CBO estimates and the most recent FMAP rates for each year, without the adjustments made by the American Recovery and Reinvestment Act (ARRA).

Other Assumptions. These estimates do not account for: increased participation for states with current Medicaid coverage levels above 133% FPL because after 2014 states are unlikely to continue to cover these individuals on Medicaid; costs associated with the increase in physician payment rates for primary care; the effects of reform for children; or the fiscal implications of the reductions of disproportionate share hospital payments. Finally, the analysis also does not account for any changes in Medicaid between 2010 and 2014. States are permitted to extend coverage to childless adults and receive their regular federal medical assistance percentages (FMAP) until 2014.

Box 2: Medicaid Match Rates for Coverage in Health Reform Summary

The health reform law establishes a new, minimum standard for Medicaid coverage that is uniform across the country and fills the biggest gaps in coverage for low-income people. Specifically, the PPACA requires states by January 1, 2014, to extend Medicaid eligibility to all groups of people under age 65 with income up to 133 percent of the FPL who are not otherwise eligible for Medicaid.[2] For most states, this will mean providing Medicaid to adults without children for the first time, as well as increasing their income eligibility threshold for parents to 133 percent of the federal poverty line. The law specifies different match rates for individuals eligible for coverage as of December 1, 2009; those made newly eligible for coverage under health reform and for certain expansion states.

- **Regular Medicaid Matching Rate**: The regular Medicaid matching rate is determined by a formula that has been in place since the program was enacted in 1965. It ranges from 50 percent to 76 percent, and is designed to provide more federal support to states with lower per capita incomes. In 2014, it will continue to be used for "already-eligible" individuals (people who qualify for Medicaid under the rules in effect on December 1, 2009).

- **Newly-Eligible Matching Rate**: The newly-eligible matching rate assures that the federal government finances much of the cost of the Medicaid expansion to 133 percent of the FPL included in the health reform legislation. It is set at 100 percent in FY2014 through FY2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond. Beginning in 2014, it is available for non-elderly adults with income up to 133 percent of the FPL who are not eligible for Medicaid under the rules that a state had in place on December 1, 2009.

- **"Expansion" States Matching Rate**: The transition-matching rate is designed to provide some additional federal help to "expansion" states (states that expanded coverage for adults to at least 100 percent of the FPL prior to enactment of health reform). These states can receive a phased-in increase in their federal matching rate for adults without children under age 65 beginning on January 1, 2014 so that by 2019 it will equal the enhanced matching rate available for newly-eligible adults. This analysis assumes that there are seven states that fall into this category: Arizona, Delaware, Hawaii, Massachusetts, Maine, New York, and Vermont.

Enhanced Matching Rates for Parents and Childless Adults, 2014 and Beyond

Year	Newly-Eligible Parents & Childless Adults (up to 133% FPL)	Medicaid-Eligible Childless Adults in "Expansion" States Only		
		Transition Percentage used to Calculate Enhanced Match	Example: State with 50% Original FMAP *Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]*	Example: State with 60% Original FMAP *Regular FMAP + [(Newly-Eligible Enhanced Match Rate – Regular FMAP) x Transition Percentage]*
2014	100%	50%	75%	80%
2015	100%	60%	80%	84%
2016	100%	70%	85%	88%
2017	95%	80%	86%	88%
2018	94%	90%	89.6%	90.6%
2019	93%	100%	93%	93%
2020 on	90%	100%	90%	90%

[2]To promote coordination, the gross income standard that will be used for the premium tax credits available in the Exchanges also will apply to most existing Medicaid eligibility groups. A standard five percent of income disregard will be built into the gross income test for Medicaid to compensate for the loss of other, existing Medicaid disregards. In addition, states will no longer be able to impose asset tests on most Medicaid populations.

Table 1: Standard Participation Scenario

	Coverage in 2019			Spending in 2014-2019 (in millions)				Change From Baseline 2014-2019			
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Reduction in Uninsured Adults < 133% FPL	State Spending	Federal Spending	Total Spending	% Federal Spending	Enrollment in 2019	State Spending	Federal Spending	Total Spending
Northeast											
Connecticut	114,083	75,864	48.0%	$263	$4,686	$4,949	94.7%	20.1%	1.2%	21.0%	11.1%
Maine	43,468	27,877	47.4%	-$118	$1,857	$1,738	100%*	11.8%	-1.5%	12.9%	7.7%
Massachusetts**	29,921	10,401	10.2%	-$1,274	$2,137	$864	100%*	2.0%	-2.1%	3.5%	0.7%
New Hampshire	55,918	34,625	48.7%	$63	$1,204	$1,267	95.0%	38.8%	1.1%	21.3%	11.2%
New Jersey	390,490	292,489	45.3%	$533	$9,030	$9,563	94.4%	38.1%	1.2%	20.9%	11.1%
New York	305,945	223,175	14.8%	$50	$8,049	$8,099	99.4%	6.0%	0.0%	3.3%	1.7%
Pennsylvania	482,366	282,014	41.4%	$1,054	$17,086	$18,140	94.2%	21.7%	1.4%	17.7%	10.5%
Rhode Island	41,185	29,147	50.6%	$70	$1,559	$1,629	95.7%	20.0%	0.7%	14.6%	8.1%
Vermont	4,484	3,214	10.2%	-$26	$112	$86	100%*	2.8%	-0.6%	1.9%	0.9%
Midwest											
Illinois	631,024	429,258	42.5%	$1,202	$19,259	$20,461	94.1%	25.8%	1.6%	25.9%	13.8%
Indiana	297,737	215,803	44.2%	$478	$8,535	$9,013	94.7%	29.4%	2.5%	22.9%	16.1%
Iowa	114,691	74,498	44.1%	$147	$2,800	$2,947	95.0%	25.3%	1.4%	15.7%	10.3%
Kansas	143,445	89,265	50.9%	$166	$3,477	$3,643	95.4%	42.0%	1.7%	24.0%	14.8%
Michigan	589,965	430,744	50.6%	$686	$14,252	$14,938	95.4%	30.2%	2.0%	21.5%	14.8%
Minnesota	251,783	132,511	44.2%	$421	$7,836	$8,257	94.9%	32.9%	1.2%	22.0%	11.6%
Missouri	307,872	207,678	45.5%	$431	$8,395	$8,826	95.1%	29.8%	1.7%	19.5%	13.0%
Nebraska	83,898	50,364	53.9%	$106	$2,345	$2,451	95.7%	36.2%	1.5%	23.5%	14.4%
North Dakota	28,864	17,198	45.1%	$32	$595	$627	94.9%	44.0%	1.4%	16.9%	10.8%
Ohio	667,376	462,024	50.0%	$830	$17,130	$17,960	95.4%	31.9%	1.6%	19.2%	12.8%
South Dakota	31,317	18,594	51.9%	$32	$717	$748	95.8%	25.9%	1.1%	16.4%	10.5%
Wisconsin	205,987	127,862	50.6%	$205	$4,252	$4,457	95.4%	20.8%	0.9%	12.7%	8.0%
South											
Alabama	351,567	244,804	53.2%	$470	$10,305	$10,776	95.6%	36.9%	3.6%	35.9%	25.7%
Arkansas	200,690	154,836	47.6%	$455	$9,401	$9,856	95.4%	27.9%	4.7%	38.9%	29.1%
Delaware	12,081	7,916	15.9%	$3	$387	$390	99.2%	6.7%	0.1%	6.2%	3.3%
District of Columbia	28,900	15,308	49.1%	$42	$902	$944	95.6%	16.1%	0.9%	8.3%	6.1%
Florida	951,622	683,477	44.4%	$1,233	$20,050	$21,283	94.2%	34.7%	1.9%	24.3%	14.3%
Georgia	646,557	479,138	49.4%	$714	$14,551	$15,265	95.3%	40.4%	2.7%	28.9%	19.8%
Kentucky	329,000	250,704	57.1%	$515	$11,878	$12,393	95.8%	37.3%	3.5%	32.2%	24.0%
Louisiana	366,318	277,746	50.7%	$337	$7,273	$7,610	95.6%	32.4%	1.7%	21.6%	14.4%
Maryland	245,996	174,484	46.2%	$533	$9,112	$9,645	94.5%	32.4%	1.7%	29.6%	15.6%
Mississippi	320,748	256,920	54.9%	$429	$9,865	$10,294	95.8%	41.2%	4.8%	37.0%	28.9%
North Carolina	633,485	429,272	46.6%	$1,029	$20,712	$21,741	95.3%	38.2%	2.6%	29.0%	19.7%
Oklahoma	357,150	261,157	53.1%	$549	$12,179	$12,728	95.7%	51.2%	4.0%	48.2%	32.7%
South Carolina	344,109	247,478	56.4%	$470	$10,919	$11,389	95.9%	38.4%	3.6%	36.0%	26.3%
Tennessee	330,932	245,691	43.3%	$716	$11,072	$11,788	93.9%	20.9%	2.5%	20.4%	14.3%
Texas	1,798,314	1,379,713	49.4%	$2,619	$52,537	$55,156	95.3%	45.5%	3.0%	38.9%	24.7%
Virginia	372,470	245,840	50.6%	$498	$9,629	$10,127	95.1%	41.8%	1.8%	35.1%	18.4%
West Virginia	121,635	95,675	56.7%	$164	$3,781	$3,945	95.9%	29.5%	2.4%	20.4%	15.6%
West											
Alaska	42,794	33,106	48.4%	$117	$2,046	$2,163	94.6%	38.5%	2.1%	36.9%	19.5%
Arizona	105,428	81,095	13.6%	$56	$2,091	$2,147	97.4%	7.7%	0.2%	4.2%	2.9%
California	2,008,796	1,406,101	41.5%	$2,982	$44,694	$47,676	93.7%	20.1%	1.5%	23.0%	12.3%
Colorado	245,730	166,471	50.0%	$286	$5,917	$6,203	95.4%	47.7%	1.8%	37.1%	19.4%
Hawaii	84,130	42,381	50.0%	-$28	$2,999	$2,971	100%*	38.0%	-0.5%	46.8%	24.0%
Idaho	85,883	59,078	53.9%	$101	$2,402	$2,502	96.0%	39.4%	2.5%	27.1%	19.4%
Montana	57,356	37,978	49.6%	$100	$2,178	$2,278	95.6%	54.5%	3.7%	40.0%	27.9%
Nevada	136,563	100,813	47.0%	$188	$3,445	$3,633	94.8%	61.7%	2.9%	49.8%	27.1%
New Mexico	145,024	111,279	52.6%	$194	$4,510	$4,704	95.9%	28.3%	2.1%	21.3%	15.5%
Oregon	294,600	211,542	56.7%	$438	$10,302	$10,739	95.9%	60.6%	3.6%	50.6%	33.1%
Utah	138,918	78,284	52.5%	$174	$4,129	$4,304	96.0%	56.1%	3.7%	35.3%	26.2%
Washington	295,662	189,463	52.2%	$380	$8,271	$8,651	95.6%	25.2%	1.2%	26.0%	13.6%
Wyoming	29,899	19,099	53.0%	$32	$683	$715	95.6%	40.0%	1.2%	26.8%	14.0%
Total	**15,904,173**	**11,221,455**	**44.5%**	**$21,148**	**$443,530**	**$464,678**	**95.4%**	**27.4%**	**1.4%**	**22.1%**	**13.2%**

*Includes newly enrolled 1115 waiver eligible population.

**Massachusetts has a low share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

Note: These estimates relate solely to the Medicaid expansion and do not account for other changes in health reform such as access to subsidized coverage in the exchanges or state or federal savings from reduced uncompensated care or the transition of individuals from state-funded programs to Medicaid in 2014.

Table 2: Enhanced Outreach Scenario

	Coverage in 2019			Spending in 2014-2019 (in millions)				Change From Baseline 2014-2019			
	Total New Medicaid Enrollees*	Previously Uninsured Newly Enrolled	% Reduction in Uninsured Adults < 133% FPL	State Spending	Federal Spending	Total Spending	% Federal Spending	Enrollment in 2019	State Spending	Federal Spending	Total Spending
Northeast											
Connecticut	154,664	113,876	72.1%	$440	$5,048	$5,488	92.0%	27.3%	2.0%	22.6%	12.3%
Maine	59,502	41,858	71.1%	-$65	$2,105	$2,040	100%*	16.2%	-0.8%	14.7%	9.1%
Massachusetts**	75,569	43,508	42.9%	-$628	$2,783	$2,155	100%*	5.2%	-1.0%	4.5%	1.8%
New Hampshire	76,744	52,146	73.4%	$117	$1,470	$1,586	92.6%	53.3%	2.1%	26.0%	14.0%
New Jersey	567,852	455,627	70.6%	$1,078	$11,129	$12,207	91.2%	55.4%	2.5%	25.7%	14.1%
New York	820,623	706,575	46.7%	$2,859	$17,170	$20,030	85.7%	16.0%	1.2%	7.1%	4.1%
Pennsylvania	682,880	458,200	67.2%	$2,041	$19,489	$21,530	90.5%	30.8%	2.7%	20.2%	12.4%
Rhode Island	53,841	40,850	70.9%	$100	$1,768	$1,868	94.6%	26.2%	1.1%	16.5%	9.2%
Vermont	15,509	13,443	42.9%	$8	$283	$291	97.4%	9.7%	0.2%	4.9%	2.9%
Midwest											
Illinois	911,830	694,012	68.8%	$2,468	$22,109	$24,577	90.0%	37.2%	3.3%	29.7%	16.6%
Indiana	427,311	337,987	69.1%	$899	$10,112	$11,010	91.8%	42.2%	4.8%	27.1%	19.6%
Iowa	163,264	117,621	69.6%	$257	$3,298	$3,555	92.8%	36.1%	2.4%	18.4%	12.4%
Kansas	192,006	131,528	75.1%	$260	$4,033	$4,293	93.9%	56.2%	2.6%	27.8%	17.5%
Michigan	812,818	635,231	74.6%	$1,096	$16,944	$18,040	93.9%	41.6%	3.2%	25.6%	17.9%
Minnesota	348,684	211,781	70.7%	$745	$9,116	$9,861	92.4%	45.6%	2.1%	25.6%	13.9%
Missouri	437,735	324,276	71.0%	$773	$10,228	$11,001	93.0%	42.4%	3.1%	23.8%	16.2%
Nebraska	110,820	71,053	76.0%	$155	$2,732	$2,886	94.6%	47.8%	2.2%	27.4%	16.9%
North Dakota	40,017	26,457	69.4%	$57	$709	$766	92.5%	61.0%	2.5%	20.2%	13.2%
Ohio	901,023	670,992	72.6%	$1,335	$19,578	$20,913	93.6%	43.1%	2.6%	22.0%	14.9%
South Dakota	41,847	27,160	75.8%	$46	$844	$890	94.9%	34.6%	1.6%	19.3%	12.5%
Wisconsin	277,116	188,043	74.3%	$314	$4,912	$5,226	94.0%	28.0%	1.4%	14.7%	9.4%
South											
Alabama	455,952	335,547	72.9%	$693	$11,404	$12,097	94.3%	47.9%	5.3%	39.7%	28.9%
Arkansas	286,347	234,695	72.1%	$761	$11,523	$12,284	93.8%	39.9%	7.9%	47.7%	36.3%
Delaware	28,839	23,317	46.9%	$90	$686	$776	88.4%	15.9%	1.6%	11.0%	6.6%
District of Columbia	38,763	22,891	73.4%	$62	$1,068	$1,129	94.5%	21.5%	1.3%	9.9%	7.3%
Florida	1,376,753	1,073,391	69.7%	$2,537	$24,260	$26,797	90.5%	50.2%	3.8%	29.4%	18.0%
Georgia	907,203	721,558	74.4%	$1,233	$17,916	$19,149	93.6%	56.7%	4.6%	35.6%	24.9%
Kentucky	423,757	337,987	77.0%	$695	$13,220	$13,915	95.0%	48.1%	4.7%	35.8%	26.9%
Louisiana	507,952	409,869	74.8%	$536	$8,937	$9,472	94.3%	44.9%	2.8%	26.5%	17.9%
Maryland	348,140	267,555	70.8%	$1,060	$10,881	$11,941	91.1%	45.9%	3.4%	35.3%	19.4%
Mississippi	419,571	350,091	74.8%	$581	$10,959	$11,539	95.0%	53.9%	6.4%	41.1%	32.4%
North Carolina	887,560	661,292	71.8%	$1,791	$24,720	$26,511	93.2%	53.5%	4.6%	34.6%	24.0%
Oklahoma	470,358	367,541	74.8%	$789	$13,436	$14,225	94.5%	67.4%	5.8%	53.2%	36.6%
South Carolina	443,020	334,296	76.2%	$615	$12,109	$12,724	95.2%	49.4%	4.7%	39.9%	29.4%
Tennessee	474,240	372,894	65.7%	$1,523	$13,128	$14,651	89.6%	29.9%	5.4%	24.2%	17.8%
Texas	2,513,355	2,055,888	73.6%	$4,514	$62,056	$66,570	93.2%	63.5%	5.1%	45.9%	29.8%
Virginia	504,466	365,514	75.2%	$863	$11,129	$11,992	92.8%	56.7%	3.1%	40.5%	21.8%
West Virginia	156,582	129,185	76.5%	$217	$4,182	$4,399	95.1%	37.9%	3.2%	22.6%	17.4%
West											
Alaska	59,914	49,061	71.7%	$219	$2,379	$2,598	91.6%	53.9%	3.9%	42.9%	23.4%
Arizona	305,634	273,008	45.6%	$739	$4,861	$5,600	86.8%	22.4%	2.9%	9.9%	7.5%
California	2,986,362	2,291,221	67.6%	$6,544	$54,936	$61,481	89.4%	29.9%	3.4%	28.3%	15.8%
Colorado	337,706	249,208	74.8%	$470	$6,925	$7,395	93.6%	65.6%	2.9%	43.4%	23.2%
Hawaii	110,203	64,167	75.7%	$30	$3,414	$3,444	99.1%	49.7%	0.5%	53.3%	27.8%
Idaho	115,730	85,523	78.1%	$133	$2,896	$3,028	95.6%	53.1%	3.3%	32.7%	23.5%
Montana	78,840	56,889	74.3%	$155	$2,558	$2,713	94.3%	75.0%	5.7%	47.0%	33.3%
Nevada	196,168	156,025	72.7%	$338	$4,100	$4,438	92.4%	88.6%	5.2%	59.3%	33.1%
New Mexico	201,855	163,105	77.1%	$278	$5,608	$5,885	95.3%	39.4%	3.0%	26.5%	19.4%
Oregon	386,845	292,651	78.4%	$555	$11,723	$12,279	95.5%	79.6%	4.6%	57.6%	37.9%
Utah	180,478	113,872	76.3%	$227	$4,695	$4,921	95.4%	72.8%	4.8%	40.2%	30.0%
Washington	395,577	276,096	76.1%	$567	$9,573	$10,139	94.4%	33.6%	1.8%	30.1%	15.9%
Wyoming	40,041	27,488	76.2%	$49	$818	$867	94.3%	53.6%	1.9%	32.0%	17.0%
Total	22,809,862	17,524,046	69.5%	$43,218	$531,958	$575,176	92.5%	39.3%	2.9%	26.5%	16.4%

*Includes newly enrolled 1115 waiver eligible population.

**Massachusetts has a low share of uninsured within the newly enrolled due to low levels of uninsurance in the baseline.

Note: These estimates relate solely to the Medicaid expansion and do not account for other changes in health reform such as access to subsidized coverage in the exchanges or state or federal savings from reduced uncompensated care or the transition of individuals from state-funded programs to Medicaid in 2014.

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